NEW MEMBER ENTRY FORM

Please answer the following questions completely, Thank You!

Name: _____Address:_____

Apt#_____ City _____State _____Zip _____Home Phone( )_____

Work Place( )_____ Cell Phone ( )_____E-Mail_____

Best Place to Reach You: □ Home □ Work □ Cell Employer:_____

Occupation:_____Duration of Employment: _____

Date of Birth:_____/_____/_____ Age: _____Social Security Number:_____

Sex: □ Male □ Female Marital Status: □ S □ M Spouses Name:_____Children:_____

How did you hear about the clinic? _____

What is your chief complaint? _____

Have you had? An MRI / X-ray before? □Yes □ No Where, When, What?_____

Is it possible you are pregnant? □ Yes □ No

Date of last Physical Exam: _____Reason:_____

Please list any accidents, falls, injuries, surgeries, and major illnesses.

TYPE	MONTH/YEAR	DESCRIBE/COMMENTS

Are you presently taking any nutritional supplements/medications?

NAME OF SUPPLEMENT/DRUG	AMOUNT	DESCRIBE/COMMENTS HOW LONG

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY

__Headaches	__Head feels too heavy	__Heart pain	__Indigestion
__Shooting pain	__Dizziness	__Heart palpation	__Intestinal gas
__Sinus pain	__Fainting	__Mid-back pain	__Low back pain
__Loss of smell	__Loss of balance	__Heart attacks	__Constipation
__Hay fever	__Ringing in ears	__High blood pressure	__Menstrual cramps
__Loss of taste	__Muscle spasms in neck	__Anemia	__Menstrual irregularity
__Tightness in throat	__Grating in neck	__Nervous stomach	__Diabetes
__Inflammation in throat	__Tight shoulder muscles	__Stomach trouble	__Swelling
__Thyroid trouble	__Neuritis-arms/shoulders	__Ulcers	__Arthritis
__Face flushed	__Pins & needles	__Nerves & nervousness	__Slipped disc
__Twitching of face	__Arms/hand pain	__Irritability	__Pinched nerve
__Loss of memory	__Cold hands	__Cold sweats	__Irregular sleep
__Fatigue	__Chest pains	__Liver trouble	__Leg/feet pain
__Depression	__Shortness of breath	__Gallbladder trouble	__Neck pain
__ _____	__ _____	__ _____	__ _____
(Other/ Please write-in)	(Other/ Please write-in)	(Other/ Please write-in)	(Other/ Please write)

Are any of your family members experiencing any of the above?

Family members: _____ Difficulties:_____

_____ _____

1 .In spite of the fact that you are not a specialist; you are in fact the person who knows more about your problem than anyone else. In your own words and in your opinion what do you think the real problem is?

_____

_____

_____

2. How long have you been like this?

_____
_____
_____

3. How has your life changed since you've had this challenge?

_____
_____
_____

4. Since your challenge became like this, what have you had to go easy at, limit or stop (Please Check)?

Daily Activities: Effects of Current Condition on Performance

- ☐ Bending
- ☐ Care –Infirm Family
- ☐ Carrying Groceries
- ☐ Change Position–Sit-Stand
- ☐ Climb Stairs
- ☐ Driving
- ☐ Extended Computer Use
- ☐ Feeding
- ☐ Household Chores
- ☐ Kneeling
- ☐ Lift Children
- ☐ Lifting
- ☐ Pet Care
- ☐ Reading (Concentration)
- ☐ Self Care–Bathing
- ☐ Self Care–Dressing
- ☐ Self Care–Shaving
- ☐ Sexual Activities
- ☐ Sleep
- ☐ Static Sitting
- ☐ Static Standing
- ☐ Walking
- ☐ Yard Work

Recreational Activity: Effects of Current Condition on Performance

_____ _____ _____
_____ _____ _____
_____ _____ _____

5. What activities are you limited in?

_____
_____
_____

6. What kind of treatments have you received?

Epidural: How Many____ When_____Physical Therapy How long/When _____
Medication:_____
Surgery: Type_____When:_____
Other:_____

7. Which treatment worked the best? For how long?

_____
_____

8. Is there anything you can do that makes it feel better?

_____
_____

9. What activities/movements are sure to make you worse?

_____
_____

10. Please describe the quality of what you feel (Sharp, Dull, Achy, Shooting, Stabbing, Numbness, Tingling, etc.) and where you have it.

_____
_____

11. Is it worse in the morning or as the day progresses? (Please Circle)

12. If you cannot find a solution to this problem what do you think will happen to you?

_____

_____

13. What are your future health care goals?

_____

_____

Most people coming into our office have one of two objectives in mind concerning their health. Some people come in for symptomatic relief of pain and discomfort (Relief Care). Others are interested in having the cause of their problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

□ Relief Care

□ Corrective Care

□ Check here if you want the doctor to select the type care appropriate for your condition

_____ _____

Date Signature

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

*Patient's Signature:*_____ *Date:*_____

*Consent to Treat Minor:*_____ *Date:*_____

Guardian or Spouse's
*Signature of Authorizing Care:*_____ *Date:*_____

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: □ Yes □ No □ Referred

_____
Doctor's Signature